ATTACHMENT 7 Sample CMS 1500 claim form for outpatient mental health services in a private clinic

PICA	HEALTH IN	SURANC	E CL	AIM F	ORM		PICA 🗆				
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP	R 1a. INSURED			OTTIM	(FOR	PROGRAM IN ITEM 1					
(Medicare #) P (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID)	HEALTH PLAN BLK LUNG (SSN) (ID) (SSN) (ID)			1234567890							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DA MM DD YY	ATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
Recipient, Im A. MM DD YY	M F X		,								
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONS 6. PATIENT RELATIONS		7. INSURED'S	S ADDRES	S (No., St	reet)						
609 Willow St Self Spouse	Child Other										
CITY STATE 8. PATIENT STATUS Anytown WI Single Marr	ried Other	CITY					STATE				
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE			TELEPHO	NE (INC	LUDE AREA CODE)				
55555 \XXX/ XXX-XXXX Stude	XXXX Student Student		()								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S COND	DITION RELATED TO:	11. INSURED		GROUP	OR FECA	NUMBE	R				
OI-P			-7								
a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (CUF	NO	a. INSURED'S	DATE OF	BIRTH YY		м [SEX F				
b. OTHER INSURED'S DATE OF BIRTH SEX b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYE	D'S MANE	3D CCUC							
MM DD YY M F T	NO i	D. EMPLOTE	N S NAME	JH SUHL	OL NAME						
c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT?		c. INSURANC	E PLAN NA	ME OR I	PROGRAM	NAME					
YES	NO										
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
		YES	<u></u>				complete item 9 a-d.				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE authorize the release of any medical or other information necessary		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for									
to process this claim. I also request payment of government benefits either to myself or to the party wh below.	no accepts assignment	services d	escribed be	low.		.g	, Jaiotal of Supplier for				
SIGNED DATE		SIGNED									
4. DATE OF CURRENT: ☐ ILLNESS (First symptom) OR ☐ 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
MM DD YY INJURY (Accident) OR GIVE FIRST DATE MM PREGNANCY(LMP)		FROM	טט	YY	Т	ОММ	DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFER	RRING PHYSICIAN	MN.	LIZATION D	ATES RI		MM	ENT SERVICES DD YY				
I.M. Referring/Prescribing 12345678 19. RESERVED FOR LOCAL USE		FROM	1 400	<u> </u>		0					
TO THE OWNER OF THE OWNER		20. OUTSIDE	LAB?	. 1	\$ CH	ARGES	1				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E B	SY LINE)	22. MEDICAID		SSION							
1 296.35		CODE ORIGINAL REF. NO.									
3.		23. PRIOR AU	ITHORIZAT	ION NUN	MBER						
2											
24. A B C D	E	F			H 1	J	K				
DATE(S) OF SERVICE TO Of STORM DD YY MM DD YY Service Service CPT/HCPCS MODIFIES		\$ CHARG	EC		mily lan EMG	сов	RESERVED FOR LOCAL USE				
12 08 03 11 90845 HP	1	XXX		2.0			1122334				
70070 11	·	1 700	777		_		1.122004				
12 15 03 11 90847 HO	1	XX	XX	1.0		L	1122335				
12 22 02 1 144 20070 1001	1	V/V	VV				4422224				
12 22 03 11 90862 U8	1	XX	XX	1.0		4—	4433221				
				+	-	\vdash					
						1					
				\top		1					
	×899 S										
			28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DU								
(F	ACCEPT ASSIGNMENT? for govt. claims, see back)	1					\$ XXX XX \$ XX XX \$ XX XX				
	YES NO	\$ X	XX XX	\$	ХХ	XX	<u> </u>				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. NAME AND ADDRESS OF FACILITY WITH RENDERED (If other than home or office	YES NO HERE SERVICES WERE	\$ X	XX XX	\$	ХХ	XX	RESS, ZIP CODE				
1234JED 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND ADDRESS OF FACILITY WI	YES NO HERE SERVICES WERE	\$ X	XX XX N'S, SUPPL	\$	ХХ	XX	<u> </u>				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	YES NO HERE SERVICES WERE	\$ X 33. PHYSICIAI & PHONE I.M. B 1 W. V	XX XX N'S, SUPPL # illing Villiam	S S	XX	XX	<u> </u>				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the stalements on the reverse	YES NO HERE SERVICES WERE	\$ X 33. PHYSICIAI & PHONE I.M. B	XX XX N'S, SUPPL # illing Villiam	S S	XX	XX	<u> </u>				